

1 July 2022

NBCSP Secretariat

National Bowel Cancer Screening Program
Department of Health
GPO Box 9848
Canberra ACT 2601

Via email: nbcspreview@health.gov.au

Dear NBCSP Secretariat,

RE: Review of Phase Four of the National Bowel Cancer Screening Program

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide feedback on the review of the National Bowel Cancer Screening Program (the Program). General practitioners (GPs) play a key role in the Program and have successfully participated since its inception.

GPs play a vital role in the effective delivery of preventive care. GPs are uniquely placed to identify and test those at higher risk, provide information to patients, and guide the coordination of treatment. Guidance is provided by the RACGP in our [Guidelines for preventive activities in general practice](#) (the Red Book) and [Smoking, nutrition, alcohol, physical activity](#) (SNAP) guide.

Feedback relating to the report is detailed under the discussion prompts from the five focus areas listed in the consultation paper.

Focus Area 1: Appropriateness of the Program

1. If the eligible age for Aboriginal and Torres Strait Islander people was lowered to 40 or 45, are there particular issues or perceptions that would need to be considered for successful implementation of this approach?

The Review of Phase Four of the National Bowel Cancer Screening Program (NBCS) recommends that the eligible age for Aboriginal and Torres Strait Islander people be lowered to 40 or 45. The lowered age of screening commencement for Aboriginal and Torres Strait Islander people needs to be based on evidence and modelling. If this does not show benefits in reducing the incidence or, mortality rate of bowel cancer, then this approach is not supported by the RACGP. Over screening is a problem and can lead to patient harm,¹ both direct, such as stress, anxiety, risks of complications with colonoscopy, and indirect where health care resources are diverted to unnecessary testing and care which could be of higher value elsewhere.

An exploration of and a focus on the barriers to screening may be more effective than lowering the age of screening commencement.

Commencing screening at 40 or 45 years of age would also need to consider the impact of possible "screening fatigue" later in the program, when there is higher risk of bowel cancer based on age.

Further, as there is limited benefit for screening patients aged over 74,² it is recommended that a patient resource about exiting the screening program after age 74 is developed and distributed to patients.

2. When following up a positive iFOBT result what is the best way to reach participants?

The current process for following up a positive iFOBT result appears to be effective for patients that are engaged with general practice. For patients who are not well engaged with general practice, and receive a positive iFOBT result, follow-up on test results is more challenging and less effective because there is no direct provider who can provide follow-up care. Encouraging patients to have a regular GP and introducing voluntary patient enrolment in Australia may, therefore, improve the effectiveness of the Program.

2.1. When following up a positive iFOBT result, are follow-up letters and phone calls useful, or would other ways of communicating be more effective?

It is best practice for general practices to have a process for recalling patients and following up clinically significant tests they have ordered.³ Clinical recalls and patient communications are easily integrated into a practice's GP electronic medical record system. The RACGP recommends the use of SMS (which identifies the sender) and email messaging, where a patient has consented use for health communications, as an adjunct to telephone or mailed results. The use of SMS with a 'reply to' facility may also be a useful way to engage people in follow up results. Multiple approaches will increase the chances of reaching patients who have received a positive iFOBT result.

It is advised that if GP recall systems are utilised to optimise NBCS screening, that incentives should be provided to participating practices to cover costs.

2.2. When following up a positive iFOBT result, is the timing for GP and colonoscopy reminders appropriate?

The timing for GP and colonoscopy reminders seems appropriate, however, GPs are often unable to report outcomes within the recommended timeframes because of long public hospital waiting lists for a colonoscopy. Patient access to timely colonoscopies needs to be improved if the Program reminders are to remain the same. Access to colonoscopy is limited for many rural and Aboriginal and Torres Strait Islander people who live outside major cities and more time is needed for colonoscopy to be done.

The RACGP recommends a system that identifies and links colonoscopy results from specialists into a registry that can be accessed from GP electronic medical record systems, ideally as part of the National Cancer Screening Register (NCSR). The system or register would streamline a way for gastroenterologists and specialists to report outcomes of colonoscopies, which will be easily accessible by GPs. Reporting of colonoscopy outcomes to the registry could potentially become a requirement for obtaining a Medical Benefits Schedule (MBS) rebate for privately conducted colonoscopies for screen detected bleeding, as well as for public hospital colonoscopy.

Focus area 2: Appropriateness of colonoscopy

3. Are you aware of developments in research that would be of interest to the Program which aim to improve standardised colonoscopy care in Australia?

To improve standardised colonoscopy care in Australia:

- Public hospital gastroenterologist clinics referral processes need to be overhauled. Referrals should be sent electronically (avoiding encrypted password locked emails which are difficult for older people to access) and triaged rapidly by a nurse, instead of via paper-based letters, which are inefficient and a safety risk.

- Patient information on preparing for colonoscopies from public hospital gastroenterologist clinics is often lacking. This is often not easy to understand and can delay colonoscopies if a patient has not prepared for the procedure correctly.
- Timely access to the results of a colonoscopy from a public hospital gastroenterologist clinic should be improved as it is also a barrier for patients who encounter long waiting times to see a gastroenterologist following a colonoscopy. Gastroenterologists communicate with patients about appointments primarily via letter (which often encounter delays). Communications should be expanded to phone, SMS or email to arrange timely appointments. Specialist letters to GPs regarding the outcome of a patient's colonoscopy are also delayed or non-existent. Delays in the communication of results potentially impacts on important follow-up support to the patient.
- Recalls for colonoscopy should be conducted as per evidence based guidelines such as the [subsequent surveillance intervals](#) section of the National Health and Medical Research Council (NHMRC) approved Cancer Council Australia Surveillance Colonoscopy Guidelines.⁴ New patient access to timely colonoscopies is often hindered by existing patients being recalled more frequently than what is recommended in the guidelines.
- As mentioned in 2.2 above, processes may be streamlined if a register (ideally the NCSR) could be developed that could prompt a recall (for a patient's next colonoscopy) which sends a patient and GP a reminder eg electronical/SMS/letter. Presently, some gastroenterologists have ceased conducting recalls. This responsibility has fallen to GPs to undertake as an unpaid task that carries substantial legal risk.
- Similarly, if a positive FOBT test appears on the register, these patients are automatically referred for a colonoscopy as occurs for imaging in the [Breastscreen](#) program.

Some research that may be of interest to the program is being undertaken by Ristanoski et al.⁵ to use artificial intelligences (AI) stratification for colonoscopies. The work investigates the opportunities to use primary care data, specifically pathology data, for developing decision tools and tackles the challenges coming from uncertainty in the data such as irregular pathology records. The study requires the use of electronic encrypted referrals rather than paper referrals.

4. What aspects of the Participant Follow-Up Function role are working well; is there anything you would change?

Recalls for colonoscopy should be conducted as per the [subsequent surveillance intervals](#) section of the NHMRC approved Cancer Council Australia Surveillance Colonoscopy Guidelines.⁵ Private specialist practices do not appear to be adhering to these guidelines.

5. Are you aware of other innovative colonoscopy access models that could be applied in an Australian context?

- The trials of Direct Access Colonoscopy services for patients with a Positive Faecal Occult Blood Test (FOBT) in [NSW](#) and [QLD](#) should be adopted widely as it is a good referral pathway.
- Expanding screening colonoscopy training to specialist nurse practitioners/technicians may improve access and reduce the cost of the procedure. As an example, nurse endoscopy programs have been implemented in Queensland⁶, South Australia⁷ and Victoria⁸ as well as in many other countries.

6. What approaches do you consider may be effective in increasing the awareness of the appropriate use of colonoscopy amongst healthcare professionals, i.e. minimising low value colonoscopies?

Other approaches that could be used to increase awareness about appropriate use of colonoscopy include:

- Accreditation of public and private gastroenterologists could include an audit against the [NHMRC approved Cancer Council Australia Surveillance Colonoscopy Guidelines](#)

- Providing more information to gastroenterologists and GPs about the appropriate use of colonoscopy amongst healthcare professionals
- Using an automated recommendation process to recall patients for screening similar to [National Cervical Screening Program](#).

7. What approaches (including audience and format) do you consider may be effective in delivering targeted education about the benefits of screening and when to refer a patient for a colonoscopy?

The audience for targeted education should be determined by a market analysis of non-participants in the Program.

Effective targeted education campaigns should be accessible via multimodal educational channels (eg TV, radio, social media, online environments, posters) which vary for different sub-populations. It is important that cross cultural and linguistically diverse resources are utilised, as well as sustainable or repeated messaging.

Focus Area 3: Governance

8. What mechanisms could be put in place to ensure that operational advice in relation to colonoscopy access is provided by the Program Delivery Advisory Group (PDAG)?

The PDAG could implement routine reporting on wait times for colonoscopy and identify whether the wait times match the [Optimal Care Pathways](#) for cancer care. Additionally, targeted campaigns could be implemented in hospitals with key performance indicators (KPIs) focused on wait times for colonoscopies. For example, a KPI could focus on wait times for patients who have received a positive FOBT.

9. When considering the promotion of the Program's key research priorities to academic organisations, what do you see as the key enablers and challenges?

To engage academic organisations, the campaign needs to provide targeted research questions and provide adequate funding to researchers in key geographical areas to address those questions. Funding should also be provided to address translational research to ensure outcomes or benefits can be applied to a real-world setting.

A challenge would be identifying the cost-benefit of the Program with respect to benefits of people participating in the Program versus those who did not participate.

10. Do you have any practical suggestions to improve/strengthen Program governance?

- Consumers should be involved in the planning and outcome assessment of the Program.
- Ensure there is no significant conflict of interests in the PDAG while maintaining broad clinician input from private and public settings.

Focus Area 4: Data Collection

11. What could the Department do to further facilitate collection of data from healthcare providers, and other sources into the National Cancer Screening Register (NCSR) to inform Program participation rate?

The RACGP recommends the following be created to inform Program participation rate:

- electronic templates that integrate into GP electronic medical record systems
- automated pathology laboratory reporting of positive or negative FOBT to the Program or NCSR

- additionally, automated pathology laboratory reporting of positive or negative FOBT to the My Health Record would allow all treating health practitioners to access the results
- distribution of iFOBT kits by pathology laboratories to support people who may lose/damage the kits and want to complete the screening test
- pathology laboratories to add people to the proposed register mentioned in question 2.2.

Many patients are referred by GPs to complete FOBT screening in pathology laboratories. Presently, this data is uncaptured in the Program. To capture this data, it is recommended that an incentive payment be linked to the upload of FOBT results to the NCSR.

12. What would encourage healthcare providers to further facilitate provision of data, including colonoscopy reports into the NCSR to enable more accurate assessment of diagnostic assessment rate and timeliness of assessment?

Financial incentives for providers may further facilitate the provision of data. Engagement with other tiers of health staff in primary care including practice nurses may also facilitate the provision of data.

Providing gastroenterologists with support to routinely report colonoscopies which have been completed, would capture all people who are being effectively screened and followed up by colonoscopy. This will decrease sole reliance on use of the iFOBT kit.

13. What changes would you make to the participation/colonoscopy patient form to improve data collection by the NCSR?

Participation/colonoscopy patient forms should be routinely completed by the gastroenterologist to improve data collection by the NCSR, along with the iFOBT reporting suggestion in question 12.

14. Do you have further comments on the evaluation of data by and for the Program, and how to improve completion of data collection?

Integrating GP electronic medical record systems with the NCSR will aid continuous quality improvement in general practice by simplifying audits into the proportions of patients engaged in bowel cancer screening and follow up.

The RACGP recommends the current screening criteria is revised to ensure that inclusion and exclusion criteria captures learnings as the Program rolls out. For example, information about those who are unsuitable for the Program are defined within the exclusion criteria and characteristics of populations that are routinely refusing testing are captured in the evaluation.

Focus Area 5: Participation

15. Do you think there are benefits to making screening kits available over the counter at pharmacies and community health organisations? Should the kits be made more widely available through GPs, rather than relying on kits being mailed out?

Making iFOBT kits available at general practices, pharmacies and pathology centres will likely increase screening rates. Evidence shows that GP endorsement/encouragement increases screening rates ⁹ as they can have targeted discussions with patients and support patients with low literacy levels to understand the mechanics of how to do the test. Making tests more freely available will enable patients to act promptly on such advice.

iFOBT kits could be distributed by pathology laboratories to support people who may lose/damage the kits and want to complete the screening test. It would also be appropriate for iFOBT kits to be dropped-off at pathology laboratories or pathology centres co-located with general practices.

We caution there is a potential for oversubscription to the Program. The NCSR may have a role in helping to manage such an eventuality.

As mentioned above in 2.2, results from the gastroenterologist could be sent to the NCSR and copied to the GP to streamline GP follow-up of results with patients. An evaluation of the Program will require a review of participants that are routinely refusing testing or late for their screening.

16. When considering the role of primary care in promoting bowel cancer screening, what are possible strategies or promotional activities that you think would best support health professionals from within this sector to increase participation in the Program?

GP electronic medical record systems already have software prompts embedded that cue age-appropriate preventative health recalls to target populations. It is recommended that GP education on setting up preventative health recalls using existing GP systems be conducted to aid future targeted colonoscopy recalls.

As mentioned above in questions 2.2 and 15, a system/registry (like the NCSR) accessible from GP electronic medical record systems to automate the linking of iFOBT and colonoscopy results from specialists or the Program would streamline communications and promote GPs' confidence to increase participation in the Program. The register should also allow GPs to remove participants from the screening target populations if there are valid reasons to do so. A copy of results uploaded to My Health Record may also aid the streamlining of information.

17. What do you see are the issues/challenges with piloting drop-off points, particularly for people living in rural and remote areas? What are some potential solutions?

Each rural/ remote area would most likely have a mail facility to post iFOBT kits to. As indicated in question 15, an alternative to the mail out program of the iFOBT kits could be to make the kits available for pick-up and drop-off at pharmacies, general practices or Aboriginal Medical Services.

18. If you could change anything with the screening kits, what would it be?

- Information provided with the iFOBT kits for patients can be streamlined and refined to reduce paper usage, for example using a QR code to access instructions.
- Simple strategies such as an opaque bag may reduce hesitancy in conducting the screening test.
- Minimise duplicate form filling for registered participants.

19. Do you have further comments on the evaluation of participation in the Program?

It is cautioned that without timely access to colonoscopies the public may start to doubt the utility of completing the screening test, particularly if the FOBT is positive nothing else is able to progress in a timely manner.

The trial of the Program iFOBT kits with Aboriginal Medical Services was a good initiative that has increased access to bowel cancer screening for Aboriginal and Torres Strait Islander people.

The Program performance indicators detailed in Table 1 are all appropriate.

The RACGP appreciates the opportunity to engage in this important consultation. For any enquiries regarding this letter, please contact Stephan Groombridge, National Manager, eHealth and Quality Care on 03 8699 0544 or stephan.groombridge@racgp.org.au.

Yours sincerely



Dr Karen Price
President

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